		FOR OHF USE					

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2000
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2000)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0027466

Facility Name: Manorcare at Elgin

Address: 180 South State (Number) Elgin (City) 60123 (Zip Code)

County: Kane

Telephone Number: (847) 742 - 3310 **Fax #** (847) 742 - 0924

IDPA ID Number: 520886946012

Date of Initial License for Current Owners: 11 / 01 / 81

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code		X	Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Craig Dekany, Reimb. Manager **Telephone Number:** (419) 252 - 5740

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 06 / 01 / 99 to 05 / 31 / 00 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment

Officer or Administrator of Provider
(Signed) _____ (Date)
(Type or Print Name) Barry Lazarus
(Title) VP of Reimbursement

Paid Preparer
(Signed) _____ (Date)
(Print Name and Title)
(Firm Name & Address)
(Telephone) ( ) Fax # ( )

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

DPA 3745 (N-4-99)

IL478-2471

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STATE OF ILLINOIS

Facility Name & ID Number Manorcare at Elgin # 0027466 Report Period Beginning: 06 / 01 / 99 Ending: 05 / 31 / 00

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	13	Skilled (SNF)	12	4,514	1
2		Skilled Pediatric (SNF/PED)			2
3	67	Intermediate (ICF)	68	24,766	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	80	TOTALS	80	29,280	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	777	1,149	1,819	3,745	8
9	SNF/PED					9
10	ICF	13,893	9,329	206	23,428	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	14,670	10,478	2,025	27,173	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 92.80%

D. How many bed-hold days during this year were paid by Public Aid?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
N/A

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 11 / 01 / 81

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 11 / 01 / 81 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 12 and days of care provided 1501

Medicare Intermediary Blue Cross of Maryland

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [ ] NO [X]

Tax Year: 12 / 31 / 00 Fiscal Year: 05 / 31 / 00

* All facilities other than governmental must report on the accrual basis.

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IF AN ERROR OCCURS IN LINE 8, 16 OR 28, PLEASE ROUND ALL CELLS IN THE APPLICABLE SECTION TO ZERO DECIMAL PLACES.

Facility Name & ID Number Manorcare at Elgin # 0027466 Report Period Beginning: 06 / 01 / 99 Ending: 05 / 31 / 00

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage	Supplies	Other	Total	Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	148,924	12,224	3,054	164,202	535	164,737	0	164,737			1
2	Food Purchase		111,984		111,984		111,984	(2,034)	109,950			2
3	Housekeeping	74,134	8,250	2,960	85,344		85,344	0	85,344			3
4	Laundry	15,860	10,197	307	26,364		26,364	(12,761)	13,603			4
5	Heat and Other Utilities			85,496	85,496	6,355	91,851	0	91,851			5
6	Maintenance	30,162	8,631	40,315	79,108		79,108	0	79,108			6
7	Other (specify):*							0				7
8	TOTAL General Services	269,080	151,286	132,132	552,498	6,890	559,388	(14,795)	544,593			8
	B. Health Care and Programs											
9	Medical Director			15,750	15,750		15,750	0	15,750			9
10	Nursing and Medical Records	992,418	87,157	45,287	1,124,862	8,753	1,133,615	0	1,133,615			10
10a	Therapy	64,962	3,036	16,717	84,715		84,715	0	84,715			10a
11	Activities	55,697	807	1,733	58,237	948	59,185	0	59,185			11
12	Social Services	7,176	186		7,362		7,362	0	7,362			12
13	Nurse Aide Training							0				13
14	Program Transportation							0				14
15	Other (specify):*							0				15
16	TOTAL Health Care and Programs	1,120,253	91,186	79,487	1,290,926	9,701	1,300,627		1,300,627			16
	C. General Administration											
17	Administrative	87,157		167,596	254,753	(56,815)	197,938	0	197,938			17
18	Directors Fees							0				18
19	Professional Services			1,097	1,097	(1,097)		0				19
20	Dues, Fees, Subscriptions & Promotions			36,078	36,078		36,078	(15,433)	20,645			20
21	Clerical & General Office Expenses	144,548	16,026	(71,043)	89,531		89,531	98,988	188,519			21
22	Employee Benefits & Payroll Taxes			287,014	287,014	716	287,730	0	287,730			22
23	Inservice Training & Education			1,910	1,910		1,910	0	1,910			23
24	Travel and Seminar			3,225	3,225		3,225	0	3,225			24
25	Other Admin. Staff Transportation							0				25
26	Insurance-Prop.Liab.Malpractice			48,309	48,309		48,309	0	48,309			26
27	Other (specify):*							0				27
28	TOTAL General Administration	231,705	16,026	474,186	721,917	(57,196)	664,721	83,555	748,276			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,621,038	258,498	685,805	2,565,341	(40,605)	2,524,736	68,760	2,593,496			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

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IF AN ERROR OCCURS IN LINE 37 OR 44, PLEASE ROUND ALL CELLS IN THE APPLICABLE SECTION TO ZERO DECIMAL PLACES.

Facility Name & ID Number Manorcare at Elgin # 0027466 Report Period Beginning: 06 / 01 / 99 Ending: 05 / 31 / 00

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			204,864	204,864	10,973	215,837	(28,334)	187,503			30
31	Amortization of Pre-Op. & Org.							0				31
32	Interest			392	392	29,632	30,024	(2,246)	27,778			32
33	Real Estate Taxes			46,524	46,524		46,524	0	46,524			33
34	Rent-Facility & Grounds							0				34
35	Rent-Equipment & Vehicles			4,532	4,532		4,532	0	4,532			35
36	Other (specify):*							0				36
37	**TOTAL Ownership**			256,312	256,312	40,605	296,917	(30,580)	266,337			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation							0				38
39	Ancillary Service Centers		52,774		52,774		52,774	0	52,774			39
40	Barber and Beauty Shops		16,139		16,139		16,139	0	16,139			40
41	Coffee and Gift Shops							0				41
42	Provider Participation Fee			43,920	43,920		43,920	0	43,920			42
43	Other (specify):*		3,785		3,785		3,785	0	3,785			43
44	**TOTAL Special Cost Centers**		72,698	43,920	116,618		116,618		116,618			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,621,038	331,196	986,037	2,938,271	0	2,938,271	38,180	2,976,451			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

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FOR LINES 1 THRU 28, ENTER ONLY ONE LINE REFERENCE PER ROW. IF SIMILAR ADJUSTMENTS ARE MADE TO MORE THAN ONE LINE, ENTER THE ADDITIONAL ADJUSTMENTS ON LINE 29 OF THIS SCHEDULE AND DETAIL THEM ON PAGE 5A.

Facility Name & ID Number Manorcare at Elgin # 0027466 **Report Period Beginning:** 06 / 01 / 99 **Ending:** 05 / 31 / 00

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7 In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(2,034)	2		4
5	Telephone, TV & Radio in Resident Rooms	(55)	21		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients	(12,761)	4		8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(2,246)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(5,485)	21		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions	(28,334)	30		15
16	Personal Expenses (Including Transportation)	(693)	21		16
17	Non-Care Related Fees				17
18	Fines and Penalties	(27,772)	21		18
19	Entertainment				19
20	Contributions	(1,250)	21		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	134,243	21		24
25	Fund Raising, Advertising and Promotional	(15,433)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ 38,180		$	30

OHF USE ONLY									
48		49		50		51		52	

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B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 38,180		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

Detail lines 29 and 35 of Page 5 starting in B44. **DO NOT DRAG AND DROP CELLS.**

The amounts in column F will transfer to the Adj. Summary column automatically.
The amounts in the Adj. Summary column are linked to pages Summary A and B.

To Print the Other Adjustments you have entered.

1. Highlight the other adjustments you have entered starting at B44 and continue to your last entry. Be sure the columns highlighted are B thru G.
2. Push the Print Other Adjustments button.

Print Other Adjustment

STATE OF ILLINOIS **Page 5A**

Facility Name Manorcare at Elgin

ID# 0027466

Report Period Beginning: 06 / 01 / 99

Ending: 05 / 31 / 00

The information listed in B13 thru G43 is from Page 5.

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	Sch V	Adj. Summary
1	Day Care	0	0	Line 1	0
2	Other Care for Outpatients	0	0	Line 2	(2,034)
3	Governmental Sponsored Special Programs	0	0	Line 3	0
4	Non-Patient Meals	(2,034)	2	Line 4	(12,761)
5	Telephone, TV & Radio in Resident Rooms	(55)	21	Line 5	0
6	Rented Facility Space	0	0	Line 6	0
7	Sale of Supplies to Non-Patients	0	0	Line 7	0
8	Laundry for Non-Patients	(12,761)	4	Line 8	(14,795)
9	Non-Straightline Depreciation	0	0	Line 9	0
10	Interest and Other Investment Income	(2,246)	32	Line 10	0
11	Discounts, Allowances, Rebates & Refunds	0	0	Line 10a	0
12	Non-Working Officer's or Owner's Salary	0	0	Line 11	0
13	Sales Tax	(5,485)	21	Line 12	0
14	Non-Care Related Interest	0	0	Line 13	0
15	Non-Care Related Owner's Transactions	(28,334)	30	Line 14	0
16	Personal Expenses (Including Transportation)	(693)	21	Line 15	0
17	Non-Care Related Fees	0	0	Line 16	0
18	Fines and Penalties	(27,772)	21	Line 17	0
19	Entertainment	0	0	Line 18	0
20	Contributions	(1,250)	21	Line 19	0
21	Owner or Key-Man Insurance	0	0	Line 20	(15,433)
22	Special Legal Fees & Legal Retainers	0	0	Line 21	98,988
23	Malpractice Insurance for Individuals	0	0	Line 22	0
24	Bad Debt	134,243	21	Line 23	0
25	Fund Raising, Advertising and Promotional	(15,433)	20	Line 24	0
26	Income & IL Personal Property ReplacementTaxes	0	0	Line 25	0
27	Nurse Aide Training for Non-Employees	0	0	Line 26	0
28	Yellow Page Advertising	0	0	Line 27	0
29	Non-Paid Workers	0	0	Line 28	83,555
30	Donated Goods	0	0	Line 29	68,760
31	Amortization Expense	0	0	Line 30	(28,334)
32				Line 31	0
33				Line 32	(2,246)
34				Line 33	0
35				Line 34	0
36				Line 35	0
37				Line 36	0
38				Line 37	(30,580)
39				Line 38	0
40				Line 39	0
41				Line 40	0
42				Line 41	0
43				Line 42	0
44				Line 43	0
45				Line 44	0
46				Line 45	38,180
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1	2	3	4	5	6	7	9	10	10a	11	12	13	14	15	17	18	19	20	21	22	23	24	25	26	27	30	31	32	33	34	35	36	38	39	40	41	42	43

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET.
IF THESE ARE NOT FOLLOWED, THE FORMULAS WILL NOT FUNCTION PROPERLY.

STATE OF ILLINOIS — Summary A

Facility Name & ID Number Manorcare at Elgin # 0027466 Report Period Beginning: 06 / 01 / 99 Ending: 05 / 31 / 00

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

Print Summary

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(2,034)	0	0	0	0	0	0	0	0	0	0	(2,034)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	(12,761)	0	0	0	0	0	0	0	0	0	0	(12,761)	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(14,795)	0	0	0	0	0	0	0	0	0	0	(14,795)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(15,433)	0	0	0	0	0	0	0	0	0	0	(15,433)	20
21	Clerical & General Office Expenses	98,988	0	0	0	0	0	0	0	0	0	0	98,988	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	83,555	0	0	0	0	0	0	0	0	0	0	83,555	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	68,760	0	0	0	0	0	0	0	0	0	0	68,760	29

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

1. Enter the information on pages 5 and 5A.
2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The amounts in the column Q are linked to page 3.

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET.
IF THESE ARE NOT FOLLOWED, THE FORMULAS WILL NOT FUNCTION PROPERLY.

STATE OF ILLINOIS — Summary B

Facility Name & ID Number Manorcare at Elgin # 0027466 Report Period Beginning: 06 / 01 / 99 Ending: 05 / 31 / 00

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

Print Summary

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	(28,334)	0	0	0	0	0	0	0	0	0	0	(28,334)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(2,246)	0	0	0	0	0	0	0	0	0	0	(2,246)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(30,580)	0	0	0	0	0	0	0	0	0	0	(30,580)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	38,180	0	0	0	0	0	0	0	0	0	0	38,180	45

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

1. Enter the information on pages 5 and 5A.
2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The amounts in the column Q are linked to page 4.

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET. IF THESE ARE NOT FOLLOWED, THE FORMULAS ON THE SUMMARY PAGES WILL NOT FUNCTION PROPERLY.

STATE OF ILLINOIS

Facility Name & ID Number: Monterrey at Elgin — # 0927466 — Report Period Beginning: 06/01/99 — Ending: 05/31/00

VII. RELATED PARTIES

Show Pgs 6A thru 6 | Show Pgs 6E thru 6 | Hide Pgs 6A thru 6

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
MasonCare, Inc.	100	Health Care & Retirement Corporation of America (SEE R.O. COST REPORT)	Toledo, OH			

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [ ] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger		4	5 Cost to Related Organization		6	7	8 Difference:	
Schedule V	Line	Item		Amount	Name of Related Organization		Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	SEE	Home Office Allocation	$ 167,550	HS & MasonCare, Inc.		100.00%	$ 167,550	$	1
2	V	PAGE								2
3	V	5								3
4	V									4
5	V	10a	Therapy Management	2,690	Heartland Management Services		100.00%	2,690		5
6	V									6
7	V									7
8	V									8
9	V									9
10	V									10
11	V									11
12	V									12
13	V									13
14	Total			$ 170,240				$ 170,240	$ -	14

Sum_6

* Total must agree with the amount recorded on line 34 of Schedule VI.

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DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

1. Enter the information on pages 5 and 5A.
2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The adjustments entered on this page will automatically transfer to the summary pages.

Line 1 Line 2 Line 3 Line 4 Line 5 Line 6 Line 7 Line 9 Line 10 Line 10a Line 11 Line 12 Line 13 Line 14 Line 15 Line 17 Line 18 Line 19 Line 20 Line 21 Line 22 Line 23 Line 24 Line 25 Line 26 Line 27 Line 30 Line 31 Line 32 Line 33 Line 34 Line 35 Line 36 Line 38 Line 39 Line 40 Line 41 Line 42 Line 43

x

Facility Name & ID Number Manorcare at Elgin # 0027466 Report Period Beginning: 06 / 01 / 99 Ending: 05 / 31 / 00

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	N/A								$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION.

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STATE OF ILLINOIS

Facility Name & ID Number Manorcare at Elgin # 0027466 Report Period Beginning: 06 / 01 / 99 Ending: 5 / 31 / 00

VIII. ALLOCATION OF INDIRECT COSTS

Show Pgs 8A thru 8 | Show Pgs 8E thru 8 | Hide Pgs 8A thru 8

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: HCR ManorCare, Inc.
Street Address: 333 North Summit St.
City / State / Zip Code: Toledo, OH 43604
Phone Number: (419) 252 -5500
Fax Number: (419) 254 -5494

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	Dietary	Accumulated Cost	100,182,693	357 Nurs. Fac.	$ 388,478	$ 221,496	137,964	$ 535	1
2	5	Utilities	Accumulated Cost	100,182,693	357 Nurs. Fac.	4,614,666		137,964	6,355	2
3	10	Nursing	Accumulated Cost	100,182,693	357 Nurs. Fac.	6,247,503	4,177,723	137,964	8,604	3
4	17	General & Administrative	Accumulated Cost	100,182,693	357 Nurs. Fac.	80,443,795	26,746,978	137,964	110,781	4
5	22	Employee Benefits	Accumulated Cost	100,182,693	357 Nurs. Fac.	520,233		137,964	716	5
6	30	Depreciation	Accumulated Cost	100,182,693	357 Nurs. Fac.	7,968,019		137,964	10,973	6
7	32	Interest	Direct Allocation	1		29,632		1	29,632	7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 100,212,326	$ 31,146,197		$ 167,596	25

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Facility Name & ID Number Manorcare at Elgin # 0027466 Report Period Beginning: 06 / 01 / 99 Ending: 05 / 31 / 00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1	Conv. Sub. Debentures		X	Facility			$ 935,949	$ 935,949			$ 29,632	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7								Interest Income Offset			(2,246)	7
8								Interest Expense Other			392	8
9	TOTAL Facility Related						$ 935,949	$ 935,949			$ 27,778	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 935,949	$ 935,949			$ 27,778	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

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Facility Name & ID Number Manorcare at Elgin # 0027466 Report Period Beginning: 06 / 01 / 99 Ending: 05 / 31 / 00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 1999 report.	$	46,524	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	46,524	2
3. Under or (over) accrual (line 2 minus line 1).	$		3
4. Real Estate Tax accrual used for 2000 report. (Detail and explain your calculation of this accrual on the lines below.)	$	46,524	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$		5
6. Subtract a refund of real estate taxes used previously to calculate a payment rate. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ _____ For 19 ____ Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	46,524	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1995	42,864	8
	1996	43,501	9
	1997	43,279	10
	1998	44,019	11
	1999	46,220	12

R/E TAX PAYMENTS
FALL 1999 23,262
SPRING 2000 23,262

FOR OHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 1999	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

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Facility Name & ID Number Manorcare at Elgin # 0027466 Report Period Beginning: 06 / 01 / 99 Ending: 05 / 31 / 00

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 20,881 B. General Construction Type: Exterior Masonry Frame Steel Number of Stories 2

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable)

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility		1967	$ 107,499	1
2					2
3	TOTALS			$ 107,499	3

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IF AN ERROR OCCURS IN LINE 35, COLUMN 4, PLEASE REMOVE THE TEXT FROM COLUMN 2 OR 3.

Show Pgs 12A & 12 | Show Pgs 12C and 12 | Hide Pgs 12A thru 12

STATE OF ILLINOIS

Facility Name & ID Number Manorcare at Elgin # 0027466 Report Period Beginning: 06 / 01 / 99 Ending: 05 / 31 / 00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	73		1967	1965	$ 562,637	$ 25,717		$ 25,717	$	$ 433,472	4
5	7			1991	325,282						5
6											6
7											7
8											8
	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3										
9	Current Year Depreciation					106,049		106,049		546,964	9
10				1987	60,759						10
11				1988	164,890						11
12				1989	26,729						12
13				1990	64,209						13
14				1991	99,431						14
15				1992	76,437						15
16				1993	62,901						16
17				1994	59,739						17
18				1995	141,422						18
19	CORPORATE OVERHEAD			1996	7,272						19
20	REPLACE CALL STATION			1996	940						20
21	INSTALL TELSET			1996	1,062						21
22	SECURE CARE DOOR			1996	1,393						22
23	WALLVINYL			1996	7,598						23
24	ARCADIA RENOVATION			1996	1,448						24
25	CARPET			1996	2,153						25
26	RENOVATION			1996	31,328						26
27	DOORS			1996	2,428						27
28	ANNUCIATOR BOX			1996	2,674						28
29	RETILE 2ND FLOOR, UTILITY ROOM, BATHROOM			1996	23,688						29
30	ELEVATOR SERVICE			1996	3,200						30
31	LIGHTING			1996	4,998						31
32	LANDSCAPE			1996	6,608						32
33	REMODELING			1996	5,335						33
34	REPAIR HOT WATER HEATER			1996	4,041						34
35	INSTALL DOOR EXIT ALARM			1996	1,943						35
36	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3				$ #VALUE!	$ 131,766		$ 131,766	$	$ 980,436	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

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IF AN ERROR OCCURS IN LINE 35, COLUMN 4, PLEASE REMOVE THE TEXT FROM COLUMN 2 OR 3.

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STATE OF ILLINOIS

Facility Name & ID Number Manorcare at Elgin # 0027466 Report Period Beginning: 06 / 01 / 99 Ending: 05 / 31 / 00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3										
9	TILE & GROUT			1996	3,877						9
10	FENCE			1996	4,625						10
11	KITCHEN REPAIRS			1996	1,928						11
12	PLUMBING/REMODEL BATHROOM			1997	17,552						12
13	CEILING REPLACEMENT			1997	10,543						13
14	WALL BACKING/KITCHEN			1997	2,894						14
15	DECORATING			1997	5,135						15
16	NURSES STATION WORK			1997	9,133						16
17	CARPET			1997	6,324						17
18	WALLCOVERINGS			1997	2,032						18
19	ASPHALT WORK			1997	3,934						19
20	CORPORATE OVERHEAD			1997	10,515						20
21	RETIREMENTS			1987	(49,105)						21
22	RETIREMENTS			1992	(6,489)						22
23	RETIREMENTS (DECORATING)			1997	(2,568)						23
24	CARPET & INSTALLATION			1997	6,011						24
25	BASEMENT CEILING WORK			1997	1,146						25
26	HVAC WORK			1997	16,458						26
27	INSTALL DOORS			1997	5,607						27
28	INSTALL WATER CONDITIONER			1997	7,051						28
29	FACILITY PLAN ALLOC.			1997	5,964						29
30	AWNING			1997	1,535						30
31	CABINETS			1997	1,377						31
32	SPRINKLER/SMOKE DETECTOR WORK			1997	1,878						32
33	PARKING LOT REPAIRS/SEALCOAT			1997	7,104						33
34	ELECTRICAL WORK/WIRING			1998	12,961						34
35	CARPENTRY - KITCHEN CABINETS			1998	6,435						35
36	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3				$ #VALUE!	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Print Previe

IF AN ERROR OCCURS IN LINE 35, COLUMN 4, PLEASE REMOVE THE TEXT FROM COLUMN 2 OR 3.

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STATE OF ILLINOIS

Facility Name & ID Number Manorcare at Elgin # 0027466 Report Period Beginning: 06 / 01 / 99 Ending: 05 / 31 / 00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3										
9	PLUMBING WORK			1998	100,949						9
10	ROOFING/SIDING WORK			1998	18,393						10
11	INSTALL DOORS/WINDOWS			1998	3,255						11
12	DRYWALL/FINISHES			1998	8,246						12
13	GENERAL CONTRACTORS FEES			1998	50,517						13
14	WALLVINYL			1998	26,268						14
15	CARPET			1998	1,790						15
16	CORPORATE OVERHEAD			1998	1,651						16
17	HVAC WORK (EXHAUST FAN)			1998	3,184						17
18	PLUMBING			1998	1,727						18
19	ELECTRICAL (CORRECTION LINE 10, PAGE 12B)			1998	(1,953)						19
20	ELECTRICAL			1998	1,242						20
21	HVAC WORK			1998	7,245						21
22	PAINTING/WALLCOVER			1998	19,710						22
23	FINISH STUD			1998	32,568						23
24	MILLWORK			1998	23,950						24
25	ROOFING			1998	505						25
26	PAVING			1998	9,256						26
27	SIGNAGE			1998	11,863						27
28	UPGRADE FIRE WET SYSTEM			1999	1,026						28
29	TELEPHONE SYSTEM			1999	1,154						29
30	HOT WATER TANK			1999	5,151						30
31	REPAIR HOT WATER TANK			1999	1,660						31
32	2 CLEAR THERMOPANES			1999	1,405						32
33	MJ ROST FREIGHT			2000	127						33
34	FRAME IN & INSTALL SET OF DOORS			1999	1,744						34
35	LAND IMPROVEMENTS			1999	12,960						35
36	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3				$ #VALUE!	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Print Previe

IF AN ERROR OCCURS IN LINE 35, COLUMN 4, PLEASE REMOVE THE TEXT FROM COLUMN 2 OR 3.

Print Page 12

STATE OF ILLINOIS

Facility Name & ID Number Manorcare at Elgin # 0027466 Report Period Beginning: 06 / 01 / 99 Ending: 05 / 31 / 00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3										
9	CONCRETE PAD & CLEANUP			1999	10,810						9
10	SEALCOAT ASPHALT			1999	1,440						10
11	RETIREMENTS			2000	(168,127)						11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
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30											30
31											31
32											32
33											33
34											34
35											35
36	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3				$ #VALUE!	$		$	$	$	36

*Total beds on this schedule must agree with page 2

**Improvement type must be detailed in order for the cost report to be considered complete

Print Previe

IF AN ERROR OCCURS IN LINE 35, COLUMN 4, PLEASE REMOVE THE TEXT FROM COLUMN 2 OR 3.

Print Page 12

STATE OF ILLINOIS

Facility Name & ID Number Manorcare at Elgin # 0027466 Report Period Beginning: 06 / 01 / 99 Ending: 05 / 31 / 00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3										
9											9
10											10
11											11
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30											30
31											31
32											32
33											33
34											34
35											35
36	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3				$ #VALUE!	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Print Previe

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Facility Name & ID Number Manorcare at Elgin # 0027466 Report Period Beginning: 06 / 01 / 99 Ending: 05 / 31 / 00

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
37	Purchased in Prior Years	$ 481,934	$ 44,764	$ 44,764	$		$ 309,537	37
38	Current Year Purchases	37,339						38
39	Fully Depreciated Assets	(30,857)						39
40	Home Office			10,973	10,973			40
41	TOTALS	$ 488,416	$ 44,764	$ 55,737	$ 10,973		$ 309,537	41

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
42	N/A			$	$	$	$		$	42
43										43
44										44
45										45
46	TOTALS			$	$	$	$		$	46

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
47	Total Historical Cost	(line 3,col.4 + line 36,col.4 + line 41,col.1 + line 46,col.4)	$ #VALUE!	47
48	Current Book Depreciation	(line 36,col.5 + line 41,col.2 + line 46,col.5)	$ 176,530	48
49	Straight Line Depreciation	(line 36,col.7 + line 41,col.3 + line 46,col.6)	$ 187,503	49 **
50	Adjustments	(line 36,col.8 + line 41,col.4 + line 46,col.7)	$ 10,973	50
51	Accumulated Depreciation	(line 36,col.9 + line 41,col.6 + line 46,col.9)	$ 1,289,973	51

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
52	STEP-UP BUILDING	$ 850,007	$ 28,334	$ 526,532	52
53					53
54					54
55					55
56					56
57	TOTALS	$ 850,007	$ 28,334	$ 526,532	57

G. Construction-in-Progress

	Description	Cost	
58	CIP	$ 5,248	58
59			59
60			60
61		$ 5,248	61

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

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Facility Name & ID Number Manorcare at Elgin # 0027466 Report Period Beginning: 06 / 01 / 99 Ending: 05 / 31 / 00

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. [ ] YES [ ] NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized by the length of the lease .

9. Option to Buy: [ ] YES [ ] NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2001	$
13.	/2002	$
14.	/2003	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [X] YES [ ] NO

16. Rental Amount for movable equipment: $ 4,532 Description: O2 Concentrators,Wheelchairs,Gerichairs, Elec. Beds, Etc.
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	N/A		$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

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Facility Name & ID Number Manorcare at Elgin # 0027466 Report Period Beginning: 06 / 01 / 99 Ending: 05 / 31 / 00

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [ ] YES [X] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [ ]
- COMMUNITY COLLEGE [ ]
- HOURS PER AIDE ____

3. CLINICAL PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [ ]
- HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

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Facility Name & ID Number Manorcare at Elgin # 0027466 Report Period Beginning: 06 / 01 / 99 Ending: 05 / 31 / 00

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service		Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	10a	1,074	hrs	$ 26,845		$ 2,708	$ 854	1,074	$ 30,407	1
2	Licensed Speech and Language Development Therapist	10a	398	hrs	9,940		342	186	398	10,468	2
3	Licensed Recreational Therapist			hrs							3
4	Licensed Physical Therapist	10a	1,127	hrs	28,177		1,407	1,996	1,127	31,580	4
5	Physician Care			visits							5
6	Dental Care			visits							6
7	Work Related Program			hrs							7
8	Habilitation			hrs							8
9	Pharmacy	39		# of prescrpts			12,260	52,774		65,034	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)			hrs							10
11	Academic Education			hrs							11
12	Exceptional Care Program										12
13	Other (specify):										13
14	TOTAL				$ 64,962		$ 16,717	$ 55,810	2,599	$ 137,489	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

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STATE OF ILLINOIS

Facility Name & ID Number Manorcare at Elgin # 0027466 Report Period Beginning: 06 / 01 / 99 Ending: 05 / 31 / 00

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 05 / 31 / 00 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 114,378	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 126,921)	189,752		3
4	Supply Inventory (priced at)	10,000		4
5	Short-Term Investments	10,000		5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	2,883		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 327,013	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	213,626		13
14	Buildings, at Historical Cost	2,787,140		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	487,684		16
17	Accumulated Depreciation (book methods)	(1,759,798)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): CIP	5,248		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 1,733,900	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,060,913	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 12,347	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	57,373		30
31	Accrued Taxes Payable (excluding real estate taxes)	11,233		31
32	Accrued Real Estate Taxes(Sch.IX-B)	46,524		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Accrued Liabilities	11,564		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 139,041	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 139,041	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,921,872	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,060,913	$	48

***(See instructions.)**

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Facility Name & ID Number Manorcare at Elgin # 0027466 Report Period Beginning: 06 / 01 / 99 Ending: 05 / 31 / 00

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 3,088,363	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 3,088,363	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	381,323	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 381,323	17
	B. Transfers (Itemize):		
18	**INTERDIVISION**	(1,547,814)	18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$ (1,547,814)	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 1,921,872	24 *

*** This must agree with page 17, line 47.**

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Facility Name & ID Number Manorcare at Elgin # 0027466 Report Period Beginning: 06 / 01 / 99 Ending: 05 / 31 / 00

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 4,012,636	1
2	Discounts and Allowances for all Levels	(1,016,615)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 2,996,021	3
	B. Ancillary Revenue		
4	Day Care	4,592	4
5	Other Care for Outpatients		5
6	Therapy	235,451	6
7	Oxygen	9,487	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 249,530	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop	693	12
13	Barber and Beauty Care	15,762	13
14	Non-Patient Meals	2,034	14
15	Telephone, Television and Radio	(55)	15
16	Rental of Facility Space		16
17	Sale of Drugs	40,602	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry	12,761	22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 71,797	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	2,246	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 2,246	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 3,319,594	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	$ 552,498	31
32	Health Care	1,290,926	32
33	General Administration	721,917	33
	B. Capital Expense		
34	Ownership	256,312	34
	C. Ancillary Expense		
35	Special Cost Centers	116,618	35
36	Provider Participation Fee		36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 2,938,271	40
41	**Income before Income Taxes (line 30 minus line 40)****	381,323	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 381,323	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

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Facility Name & ID Number Manorcare at Elgin # 0027466 Report Period Beginning: 06 / 01 / 99 Ending: 05 / 31 / 00

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	3,234	3,493	$ 60,294	$ 17.26	1
2	Assistant Director of Nursing					2
3	Registered Nurses	8,495	10,035	222,705	22.19	3
4	Licensed Practical Nurses	11,062	12,416	202,349	16.30	4
5	Nurse Aides & Orderlies	42,018	49,522	501,630	10.13	5
6	Nurse Aide Trainees					6
7	Licensed Therapist	3,647	3,988	20,218	5.07	7
8	Rehab/Therapy Aides	1,989	3,107	44,744	14.40	8
9	Activity Director					9
10	Activity Assistants	5,868	6,352	55,697	8.77	10
11	Social Service Workers	415	676	7,176	10.62	11
12	Dietician	14,608	16,233	148,924	9.17	12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants					15
16	Dishwashers					16
17	Maintenance Workers	1,838	2,199	30,162	13.72	17
18	Housekeepers	9,129	9,890	74,134	7.50	18
19	Laundry	1,112	1,349	15,860	11.76	19
20	Administrator	1,885	2,080	87,157	41.90	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	9,936	10,791	144,548	13.40	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	579	689	5,440	7.90	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	115,815	132,820	$ 1,621,038 *	$ 12.20	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant		$		35
36	Medical Director				36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	149	10,5	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	Monthly	948	11,5	44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 1,097		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	1,326	$ 29,425	10,3	50
51	Licensed Practical Nurses	161	2,617	10,3	51
52	Nurse Aides	370	6,526	10,3	52
53	TOTAL (lines 50 - 52)	1,857	$ 38,568		53

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STATE OF ILLINOIS

Facility Name & ID Number Manorcare at Elgin # 0027466 Report Period Beginning: 06 / 01 / 99 Ending: 05 / 31 / 00

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Maureen Schmitt	Administrator	0.00%	$ 87,157
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 87,157

B. Administrative - Other

Description	Amount
Management Fees	$ 167,596
TOTAL (agree to Schedule V, line 17, col. 3)	$ 167,596
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
	Activities	$ 948
	Pharmacy	149
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 1,097

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 18,705
Unemployment Compensation Insurance	
FICA Taxes	141,484
Employee Health Insurance	115,584
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Appreciation	379
Retirement Plan Expense	9,261
Other Employee Benefits	285
Employee Vaccinations	978
Employee Uniforms	338
Home Office Allocation	716
TOTAL (agree to Schedule V, line 22, col.8)	$ 287,730

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 0
Advertising: Employee Recruitment	16,066
Health Care Worker Background Check	0
(Indicate # of checks performed)	
Advertising	14,422
Public Relations	1,011
Dues & Subscriptions	4,579
Less: Public Relations Expense	(1,011)
Non-allowable advertising	(14,422)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 20,645

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$ 2,544
In-State Travel	391
Seminar Expense	290
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 3,225

* Attach copy of IMRF notifications

**See instructions.

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Facility Name & ID Number Manorcare at Elgin # 0027466 Report Period Beginning: 06 / 01 / 99 Ending: 05 / 31 / 00

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1997	FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005
1	N/A		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

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Facility Name & ID Number Manorcare at Elgin # 0027466 Report Period Beginning: 06 / 01 / 99 Ending: 05 / 31 / 00

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **NO**

(2) Are there any dues to nursing home associations included on the cost report? **YES**
If YES, give association name and amount. **IHCA 3074**

(3) Did the nursing home make political contributions or payments to a politica
action organization? **NO** If YES, have these costs
been properly adjusted out of the cost report?

(4) Does the bed capacity of the building differ from the number of beds licensed at the
end of the fiscal year? **NO** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **YES**
What was the average life used for new equipment added during this period?

(6) Indicate the total amount of both disposable and non-disposable diaper expense
and the location of this expense on Sch. V. $ **27,007** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures
consistent with prior reports? **YES** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **NO**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for
Schedule VII)? YES NO **X** If YES, please indicate name of the facility,
IDPH license number of this related party and the date the present owners took over

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department
of Public Aid during this cost report period. $ **43,920**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V
for an individual employee? **NO** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to
the Department of Public Aid, in addition to the daily rate, been properly classified
in the Ancillary Section of Schedule V? **YES**

(14) Is a portion of the building used for any function other than long term care services for
the patient census listed on page 2, Section B? **NO** For example,
is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach
a schedule which explains how all related costs were allocated to these functions

(15) Indicate the cost of employee meals that has been reclassified to employee benefits
on Schedule V. $ **N/A** Has any meal income been offset against
related costs? **YES** Indicate the amount. $ **2,034**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **NO**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for
residents? **NO** If YES, please indicate the amount of income earned from such a
program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **N/A**
d. Have vehicle usage logs been maintained? **N/A**
e. Are all vehicles stored at the nursing home during the night and all other
times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjusted
out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such
transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? **NO**
Firm Name: The instructions for the
cost report require that a copy of this audit be included with the cost report. Has this copy
been attached? If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted ou
out of Schedule V? **YES**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services
performed been attached to this cost report? **N/A**
Attach invoices and a summary of services for all architect and appraisal fees.